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# Going Under and Coming Round: Anesthesia, Narrative, and Trauma

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## Abstract

General anesthesia is of course valued for sparing patients the physical pain and psychological trauma of being sensate and conscious during surgery, but it also poses a specific challenge to the narrative continuity often seen as a defining aspect of human identity and of mental health. The patient is (arguably) absented from the scene in which his or her body is (arguably) traumatized, and then returns to awareness to find a body that has been changed. This rupture in continuity presents a challenge to coherent first-person narration. Examining some of the strategies used by writers to represent the gap opened up by anesthesia, I suggest that such accounts illuminate our understanding of the connections between narrative rupture, trauma, and an ethical responsibility to recognize the possibility of sentience, and hence the capacity for suffering, in anaesthetized patients.

## Keywords

Anesthesia; surgery; narrative; trauma; medical ethics

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In her memoir *Girl Interrupted*, Susanna Kaysen describes undergoing a dental extraction. The experience begins with a conventional indicator of quantified awareness: the dentist tells her to "'Lean back and count to ten" (Kaysen 107-8). What follows feels like a fold in chronology: "Before I got to four I was sitting up with a hole in my mouth." Kaysen asks the dentist, "Where did it go?" and he shows her "my tooth, huge, bloody, spiked, and wrinkled." But this is not what matters for Kaysen: "I'd been asking about the time," she says; "I was ahead of myself. He'd dropped me into the future, and I didn't know what had happened to the time in between." Kaysen articulates the problem of anesthesia as a problem of lost time, of biographical as well as bodily rupture.

The interchange also reveals a clinical disconnect: Kaysen's dentist trusts that seeing the bloody tooth will satisfy her because it is material evidence of what happened during the lost time and because its shows that she was protected from experiencing that violent event. But Kaysen feels more violated by the extraction of her self from time, and this is exacerbated by the refusal of those who were awake to help her recuperate the loss. When she asks the dentist how long the procedure took, he doesn't know precisely and isn't interested in telling her, even when she insists, "It's my time and I need to know how much it was." Setting aside questions of Kaysen's narrator as reliable or generalizable, we see her point: something significant has happened to her experience of continuity, and her health care provider does not think it matters.

But patients may sometimes need assistance in measuring and recounting the operative period, the time between going under and coming round. Anesthesia can challenge the

security of a self constituted as continuous over time, and a clinical failure to support reconstitution of that self may result in trauma. Instances of "intraoperative awareness," when experience is both present and registered, might help explain both the trauma anesthesia can cause and medicine's limitations in addressing it, but these concerns may be applicable even in anesthetically successful operations, when (as far as anyone can tell) the patient has no experience of the surgery.

First, though, a clarification: in what follows I will suggest that general anesthesia may promote or exacerbate certain harms. It should go without saying that I do *not* mean to suggest that surgery would be better or less psychologically harmful without anesthesia. Perhaps the best-known account of such an experience, written in 1812 by the novelist Fanny Burney, offers insight into the trauma surgery entails and also reveals the importance of recuperating the self afterwards, of "tying together what passed" (Burney 443). Burney describes undergoing her own mastectomy, conveying her perceptions with careful precision: "When the wound was made, and the instrument was withdrawn, the pain seemed undiminished, for the air that suddenly rushed into those delicate parts felt like a mass of minute but sharp and forked poniards, that were tearing the edges of the wound…" (Burney 442).[1] My point is that anesthesia is not an absolute palliative for surgical trauma, and that its more complex challenges are easier to overlook than the unquestionable physical and mental suffering caused by what amounts to vivisection (albeit for beneficent ends). Burney's letter suggests that she developed what we might now diagnose as post traumatic stress:

> for Months I could not speak of this terrible business without nearly again going through it! I could not think of it with impunity! I was sick, I was disordered by a single question - even now, 9 months after it is over, I have a headache from going on with the account! & this miserable account, which I began 3 Months ago, at least, I dare not revise, nor read, the recollection is still so painful. (442-3)

Yet Burney persisted in reliving and narrating the events of her ordeal. Why? Theorists of trauma have long argued that a traumatizing event can be tolerably assimilated through its reconstruction in narrative form. Significant, then, is Burney's recollection that for some moments during her ordeal she was *not* conscious: "Twice, I believe, I fainted; at least, I have two total chasms in my memory of this transaction, that impede my tying together what passed" (443). We might expect Burney to describe passing out as a blessed escape from torment. Instead she regards these moments—of being anesthetized by her own body—as an impediment to "tying together" the experience. This untying of experience, resonant with Kaysen's sense of lost time, points to the surgical event as traumatizing as physical violation, but also as a personal event the subject may be prevented from recalling and recounting.

Medicine and its content pose many challenges to narration. How do we (patient or clinician) tell, for example, what a particular pain really feels like? How do we tell (know and narrate) about early disease emerging inside a body? How do doctors prognosticate, or tell the future? And, in the present case, should we even *want* to be able to tell what happens during surgery? One patient's optimistic account of obliteration and resurrection is a widely accepted ideal: "The thought of having someone knock me out and then bring

[1] Burney's account has become somewhat canonical in discussions of the history of surgery and pain. See, for example, Snow 1-3; Tougaw 65-67.


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me back to life when I'm all fixed comforts me" (Dale 53). In practice this may not be so simple.

Anesthesia raises three related questions for me, regarding narratability, trauma, and ethics. First, if we associate human identity and mental health with a continuous and coherent narrative account of the self, what does it mean that anesthesia makes of surgery an absence, turning a significant event in the patient's life into a biographical gap? How have Fanny Burney's surgical descendants narrated *their* operations? What formal strategies are available for recounting this experience—or non-experience—and what can we learn from such efforts? Second: while we assume that conscious surgery is traumatic, the gap produced by anesthesia might illuminate existing theories about trauma and representation. Is it possible to be traumatized by a non-experience? Finally, an ethical claim follows from this: medicine has a moral responsibility to recognize the potentially traumatic effects of anesthesia, and to acknowledge the potential effect of this temporary and apparent (but not inevitable) lack of sentience on the moral status granted to the anesthetized patient? By extension, what about other patients whose sentience cannot be definitively verified (the comatose or those in minimally conscious states, for example)? We rely for evidence of sentience on the subject's ability to indicate feeling, to express what it feels like, or to tell a retrospective account of how it felt. We risk discounting the experiential reality of what may be felt but not communicated or recalled. Anesthesia's conventional countdown to oblivion may mark only the subject's loss of the ability to count aloud, or to recount afterward what came between "three" and "four." It does not inevitably denote the extraction of feeling self from a body rendered inanimate.

## 1. The Unnarratable

> I'm gone.
> Jamieson Dale, *Chasing Beauty* (54)

Narratability is determined by events' availability to take conceptual form as a story (the events must be knowable or imaginable); by a teller with the capacity to tell the story; and by the possibility for it be heard and accepted as a story (the narration must convey the story coherently and the story must be tolerable—not so distressing or offensive that a listener/reader will interrupt or flee).[2] Anesthesia challenges all three requirements: key events are inaccessible or distorted; the patient may not remember them; and, importantly, probable listeners—clinicians, family members—cannot accept what narrative traces may emerge. For the anesthetist, a story about experience during anaesthetized surgery denotes a serious failure. Medicine is motivated to view the period between going under and coming round as intentionally unnarratable because no possibility of story exists there.

One way to narrate anesthetized time, then, is to speculate, inventing fictional but narratable events. For example, H.G. Wells's short story "Under the Knife" (1896) is narrated by a surgical patient who, despite chloroform, apparently remains alert throughout the surgery that almost kills him. Wells's account is worth comparing with Burney's: "I fell motionless and a great silence, a monstrous silence and an impenetrable blackness came upon me. There must have been an interval of absolute unconsciousness, seconds or minutes. Then with a chilly, unemotional clearness, I perceived that I was not yet dead. I was still in my body" (Wells 54). He recounts retrospectively, as Burney did, what he has

[2] On the unnarratable, see *Routledge Encyclopedia of Narrative Theory*, 623.


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survived. The absolute unconsciousness is a gap in time—he cannot tell its duration—but the chloroform has severed perception from feeling (we might say he remains sensible but not sensitive): "all the multitudinous sensations that come sweeping from [my body] to make up the background of consciousness had gone …. Haddon [the surgeon] was bending over me …. It was interesting to see myself cut like cheese, without a pang, without even a qualm" (Wells 55).

When a nicked blood vessel begins the hemorrhage that almost kills him, the patient's experience expands into a sort of cosmic time travel, with anaesthetized—and near-death—time vastly expanded rather than compressed to the nothing that most surgical patients recall: "my sense of duration had changed; … my mind was moving not faster but infinitely slower …. it appeared as if the time between thought and thought grew steadily greater, until at last a thousand years was but a moment in my perception" (Wells 60). The patient has been depressed before the surgery. Now, when he returns to his body, he experiences great relief: "I perceived, suddenly, that the dull melancholy of half a year was lifted from my mind" (63). His near-death experience registers both as experience and as memorable, his imagined/recorded awareness possibly beginning as a failure of anesthesia, but disconnecting his consciousness from the chronotope of the operating room, culminating in an apprehension of the divine. Wells's story suggests a continuity between the experience of anesthesia and of nearing death, and for him both are spiritually therapeutic. The anomaly, though, is that his fictitious narrator remembers enough to tell the story.

Non-fiction autobiographical accounts of surgery usually come to a halt as the patient goes under. They recount a failure of memory, or rather a memory that finds nothing to remember. Time is not expanded or transcended in these narratives; it is erased, and this erasure is typically thought of as a good thing. An anesthesiology web site providing information for anxious presurgical patients informs them that "the first thing most people ask" as they emerge from anesthesia is "When are you going to start?"[3] This is intended to reassure by constituting anaesthetized surgery as a non-experience, where the end of the process laps one's anticipation of its beginning. This loss of time is seen as small price for avoiding intolerable pain.

As medical technology advances, it can more effectively extract the patient's sensate self from the surgery. Sylvia Plath's 1950s poem "Face Lift" gives us a mini-history of surgical experience in the 1940s and '50s by recounting two experiences of anesthesia. The speaker remembers the first operation as an event from her childhood: "When I was nine, a lime-green anesthetist / Fed me banana gas through a frog-mask. / The nauseous vault / Boomed wild bad dreams / and the Jovian voices of surgeons. / The mother swam up, holding a tin basin. / O I was sick." Plath's adult speaker remembers and recounts her experience as at once dreamlike—nightmarish—and distancing. But she has had a second, more recent operation with improved technology. This version is told in present tense, for there is nothing for her to look back on: "At the count of two / Darkness wipes me out like chalk / on a blackboard . . . / I don't know a thing." The ellipsis is in the original, replacing the nauseatingly colorful chloroform twilight of the earlier technology.

But chalk, of course, always leaves dusty traces on the blackboard. No longer legible, they are still present, demanding representational strategies. In her account of gastric bypass surgery for weight loss, Jen Larsen builds a visible spatial gap into the typography of her story:

[3] Australian Society of Anaesthetists, *All About Anaesthesia: Information for Patients*. web. 2016. http://www.allaboutanaesthesia.com.au/


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> "Ten," I said. I breathed in deeply, closed my eyes. "Nine," I said. "Eight."
> *Surgery.*
>
> [A blank space to the bottom of the page; the next page begins:]
>
> When you come out of anesthesia, it feels like you've got your eyes closed even when they're open. (112-3)

The difficulties of telling about anesthetized experience are addressed by *showing* it instead. Jamieson Dale's account of cosmetic surgery uses a similar convention:

> I succumb to the drug's effect. I'm gone.
>
> *
>
> At home after the surgery, I hesitantly peer into the mirror. (54)

The asterisk serves a similar purpose in Jon Reiner's account of abdominal surgery for Crohn's disease:

> Lying on the operating table, … I'm comfortable…. I am adrift on a life raft, receiving the pleasure of peace, before losing myself to the anesthesia filtering in.
>
> *
>
> "Jon, are you awake?" J.P. has pulled open the bed curtain … (48-9)

Some do try to write within that gap, and have to struggle at the limits of narratability. In her account of mastectomy, a far cry from Fanny Burney's, Geralyn Lucas uses disnarration (telling what did not take place, but might have) to construct a conditional presence that gradually inserts her narrating self into the experience.[4] She begins her account in much the way others have: "I think I am ready…. I taste the lipstick in my mouth and it is mingling with the anesthesia cloud that has made me very sleepy and then—I am out" (54-55).

But then she describes what she *would* be seeing were she conscious and connected: "If I were awake I would see Dr. B slicing away the mound of flesh that was my breast and carefully placing it in the pathology container. If I were awake I would hear the beeping of my heart" (55). The verb tenses mark this not as retrospective but immediate, not "if I *had* been awake I *would* have…" but "If I were awake now the experience would be like this, but I am not, so I have to imagine this, now." This immediacy allows her to recuperate both presence and, owning her decisions both to have the surgery and to wear lipstick, a degree of control and empowerment within the process itself: "If I were awake I would tell them [now, not before or after] how proud I am that I decided to cut off my breast" and now, no longer conditionally, she claims an immediate though presumably impossible emotion: "Under anesthesia, with a tube forced down my throat, I am hopeful and maybe even a little sexy" (55). The lipstick, signifying her presence as a subject despite her unconsciousness, is replicated by the effect of Lucas's prose in writing across and through the temporal gap of anesthesia, claiming the experience for a reasserted self. For most,

[4] See Prince, 1-8.


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though, anesthesia renders surgery a non-experience over which their only claim is that of the obtunded body.

## 2. Trauma

> The traumatized … carry an impossible history within them, or they become themselves the symptom of a history that they cannot entirely possess.
> Cathy Caruth, *Trauma: Explorations in Memory* (5)

What place, then, might anaesthetized time take in the history of a patient? Is it excessive to imagine that place as a wound, even if the wounding event cannot be recounted? In their article on post-traumatic stress symptoms in patients after orthopedic surgery, Julie K. Cremeans-Smith and her co-authors acknowledge that an operation is "a scheduled trauma" (56). The physical aspects of such a trauma are largely controllable because they are expected; the psychological aspects are unpredictable, for we tend to trust that anesthesia will prevent mental trauma. Yet resurrection after being "knocked out and brought back to life all fixed" can be a fairly shattering experience. Geralyn Lucas describes coming round as her delivery into a future dreaded from the far side of an unimagined threshold: "All I can see when I try to open my eyes is the white bandage where my right breast used to be. This is the moment I've been dreading: I have woken up … and a piece of me is gone" (56). Like Kaysen's concern about losing time as well as tooth, Lucas (narrating well after the surgery) registers that, despite her efforts to insert herself into surgery's accounting, her return was marked first by loss.

Efforts to write across the empty space in anesthesia narratives seem to resonate with Cathy Caruth's account of trauma, where literary representation stands in for a repressed traumatic history. Caruth calls the traumatizing event an "unclaimed experience," apprehended in a way that could not be integrated into coherent self-narration. She argues that imaginative fiction must do the work of processing trauma because non-fiction recall and recounting cannot: "trauma is not locatable in the simple violent or original event in an individual's past, but rather in the way that its very unassimilated nature—the way it was precisely *not known* in the first instance—returns to haunt the survivor later on" (4).

It may be that anesthesia leaves the "scheduled trauma" of surgery quite literally unassimilated: the fact that the event has happened is made evident by the body's wounds, but the lived time of it is blocked to the subject, maybe because the subject was not sentient, but maybe because drug-induced amnesia has set the trauma beyond assimilable recall. H.G. Wells's narrator recognizes that it may be his memory of surgery rather than his experience of it that is anomalous: "I wondered if everyone perceived things in this way under chloroform, and forgot it again when he came out of it. I would be inconvenient to look … and not forget" (55). Non-fiction accounts are left to disnarrate, as Lucas does, or simply to represent the gap itself, figuring the event of surgery, even if crucial to the author's plot, as erasure. Yet, like Plath's chalk marks, it will leave traces.

Caruth's model for trauma has been called into question—most recently by Richard McNally's documenting that traumatizing events tend to produce not amnesia but its opposite: vivid, though possibly distorted, imprints of experience. Yet major surgery with general anesthesia seems, despite its beneficent intent, an exemplary case study in Caruth's "unclaimed experience," potentially leaving psychological and cognitive damage, the subject made symptom of her impossible history. Non-fiction accounts of coming round after surgery, like Lucas's, record dissonance between evidence of the body's experience and a


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mind returning to find that things have changed. Jamieson Dale registers horror for the first time on seeing the effects of her cosmetic surgery: "*My face*. It is unrecognizable. I'm unrecognizable.… Something serious was done to me, to my face. Now I can't help but think about the scalpel part of this. My face was *cut open*, and stuff was moved around and inserted and taken out. It's kind of exciting but also sickening" (53-4).

Similarly, Jen Larsen confronts "the scalpel part" but finds herself unable to imagine what happened: "The nurse had told me about the breathing tube, but I couldn't imagine a tube threaded down through my throat. I couldn't imagine surgery. I couldn't imagine that such a huge chunk of my insides was gone" (114). She cannot narrate what she cannot imagine—what her mind cannot grasp—even though she was there, and it happened to her. In this reconstitution of self, Larsen ponders her surgery as a kind of irretrievable rebirth into being a different (in her case, thin) person: "I wondered how much weight I had lost already, how much muscle and intestine had been dragged out of my body and discarded" (115). She assimilates the loss, both of unwanted flesh and of violent time, as signs of a prehistory that anesthesia has split off from her new present. Her words, reconstituting the verb tenses needed for narration, show the emergence of a new history : "I wondered when it would start. It was about to start. It was starting. It had started" (115). These words mark the end of part one of her memoir. An illustration on the next two pages graphically disarticulates her pre- and postsurgical selves, showing a piece of paper with a strip ripped out of it, and the second part's title, "the imaginary after" (116-117).

This rupture is often seen as negligible, as Kaysen's dentist demonstrates by refusing to acknowledge that her lost time means anything but pain avoided. It is coming to be recognized, though, that anesthesia is not as absolute an erasure as we might trust it to be. It is possible that the experience of being under anesthetic is unnarratable not because there was no experience, but only because it cannot be remembered. Anesthesia intentionally causes amnesia. Where for Burney surgery was agonizing to retell because it was so painful to recall and (almost) too horrific for a reader to receive, contemporary surgery may be untellable because the patient has been rendered incapable of remembering events that may—as Caruth posits is the case with much trauma—in fact have been experienced. This raises questions for medical ethics.

## 3. Ethics

> [P]eople are generally aware of more things than they remember.
> Kerssens et al, *Anesthesiology* (570)

Anesthesia is not the same as deep sleep. The drugs currently used are intended to produce three distinct effects: unconsciousness, paralysis, and amnesia. These three goals are not always equally achieved. If the first fails and the patient is conscious and aware, the second makes it impossible to communicate such awareness as it happens, and the third renders it unreportable in retrospect. The anaesthetized mind is not temporarily turned off. We may think of it as left trapped inside an unresponsive body it cannot protect, or as cut off, both from the body and from its own past and future. As Wells imagined it, the anaesthetized mind may experience infinite duration between the counts of "three" and "four." We—it—can't tell. But as with all history, we know that being unable to tell that something happened does not mean that nothing happened, or that is had no effects.

Incommunicable subjective experience is a problem for medical ethics. Others' pain is hard enough to grasp; a sentient mind in an immobile body being dissected is the stuff of


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nightmares. Richard Blacher begins his 1975 article on "awakening paralyzed during surgery" with an epigraph from Claude Bernard, the 19th-century physiologist responsible for much of contemporary anesthesia design. Bernard warned that the use of curare to paralyze surgical patients could have serious consequences if unconsciousness did not persist: "In all ages poetic fictions which seek to arouse our pity have presented us with sensitive beings locked in immobile bodies. Our imagination cannot conceive of anything more unhappy.…The torture which the imaginations of the poets has invented can be found produced in nature by the action of the American poison [curare]."[5] This unhappiness is inconceivable not only because of its extremity, but because it is usually unnarratable.

Medicine is reassured by treating retrospective narratability as necessary evidence of experience, and of harm. Amnesia is understood, then, as making traumatization impossible. Definitions such as the following function to exclude the possibility of surgical experience that is, in Caruth's terms, *unclaimed*: "Intraoperative awareness is an unwanted outcome that consists of an explicit recall of events during a surgical procedure performed under general anesthesia" (Vulser et al 94). By this syntax, awareness is a post hoc outcome of surgery and is limited to what the patient can recall explicitly—that is, verifiably by others who were there and awake. Yet even by this limited definition, intraoperative awareness occurs in about 1 out of 1000 surgical cases, and can have serious consequences, as Vulser shows: "acute and posttraumatic stress symptoms (sleep disturbances and recurrent nightmares, flashbacks, anxiety, fear about future anesthesia and hospital avoidance) that may lead to full-blown … PTSD in up to 71% of cases after IA" (94).

The corollary of making it hard for patients to remember surgery is that it becomes easier for health care providers to treat the experience of anesthetized surgery as, from the patient's perspective, non-existent. Robert Sanders and his co-authors warn, though, against the danger of anesthetists' trusting that the unresponsive patient—unable to communicate experience by wincing or withdrawing, if not by vocalizing—is necessarily unconscious—not experiencing. The purpose of anesthesia, they point out, is to "prevent the experience of surgery" altogether. Alarmingly, Sanders et al point to "a large body of opinion that follows a utilitarian approach, and insists that unconsciousness *per se* is not a requirement for the state of general anesthesia, but that amnesia plus immobility are the minimal necessary components" (947). By implication, anesthesia has been successful as long as the consequences of being conscious during surgery are not narratable—even if, for instance, the patient begins to suffer mysterious post-traumatic symptoms like nightmares and panic attacks but can't say why. Nonetheless, unexplained depressive disorder or sudden cognitive decline have been recorded in perhaps a third of patients after major surgery.[6]

Imaginative researchers have developed a way to establish sentience during anesthesia independent of recall, simply by isolating patients' forearms from paralysis and asking them to respond with hand squeezes to questions asked during the operation. Chantal Kerssens and her co-authors frame this study with a careful (re)definition: "we distinguish the literal meaning of awareness, referring to conscious subjective experiences, from the common definition used by anesthesia staff, referring to postoperative remembering what happened during surgery" (570). Only a quarter of the patients who responded unequivocally to commands given while they were anaesthetized were able to recall the surgery afterwards.

[5] Barnard, "La curare," 1878, qtd in Blacher, 67.
[6] See for example Ghoneim and O'Hara, who report a 30-40% rate of depression and other psychological impairments following coronary bypass surgery.


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A different study found that seven out of thirty patients developed severe anxiety after cardiopulmonary bypass surgery. Two of them had what the author calls "narrative memory" of being alert during the surgery, but another five were able "to tell a story of what happened" under hypnosis (Osterman 274). The amnesia was, it seems, a relatively shallow patch over vivid experience: one man "described his leg being cut, hearing voices, and feeling as if he 'wasn't going to pull through it'"; he then "became flushed and uncomfortable and spontaneously terminated hypnosis."[7] The amnesia was restored. Setting aside the ethics of subjecting a patient through hypnosis to what turned out to be (re)traumatizing, the diagnostic value of the experiment is significant—postsurgical psychopathology may well be caused by the unclaimed experience of intraoperative awareness.

Anesthesia, then, in separating awareness from memory, generates a narrative rupture or gap for the patient that, while it registers as a lacuna like that blank space on the page of a memoir, may be populated with horrors. (Or, in some cases it may even be filled with the wonders H. G. Wells imagined—the point is we can't tell.) The gap demarcated by anesthesia may also correspond to an unnarrated gap in medical knowledge, an aporia in medicine's attention to persons: what if the subject's self is present in places where medicine really hopes it is not? It is a basic ethical presumption that sentient beings have greater moral claims than non-sentient beings. Inducing amnesia thus risks diminishing the moral status of anesthetized patients regarding events that clinicians trust will be erased afterward by amnestic drugs. For example: surgeons have to been known to say things during surgery that they would not dream of saying if they imagined the patient could hear them, and medical students have been expected to practice unindicated procedures on anesthetized patients (see Wall and Brown). If the patient wasn't mentally present when it happened and remembers nothing, goes the implicit rationalization, then it didn't happen *to her*.

There is an imperative here, then, for clinicians to assume uncertainty. The patient's surgical experience, at whatever level of intraoperative awareness, must not meet with medicine's rejection of the possibility that sentience exists where, biologically, it is not supposed to. Even if we could be certain that ablation of experience was complete, the clinician—like Kaysen's dentist—is accountable for the patient's lost time and should be responsible for helping to restore it.

There is evidence that co-construction of a narrative that bridges the surgical gap is effective. In 1975 Richard Blacher described a "syndrome of traumatic neurosis" in patients who "awakened from light anesthesia while still unable to move" (67). They developed "symptoms of anxiety and irritability, preoccupation with death, and repetitive nightmares." Blacher urged physicians to suspect intraoperative awareness in such patients, even though, he says, the patient might be reluctant to talk about it. Blacher attributes patients' unwillingness to tell what happened to their fear that the experience was a delusion or that others will dismiss it as just a dream. He reports finding that a "direct explanation of the situation often serves as a dramatic cure" of the psychiatric symptoms (67).

Blacher's article was published long ago, yet I suspect fear of admitting failure, and fear of liability, still makes admitting the probability of intraoperative awareness unlikely. In fact, medicine may be quite invested in sustaining the illusion that awareness and experience can be limited to what can be remembered and narrated. The things medicine has difficulty narrating are often things turned away from because they are too horrific to contemplate.

[7] Janet E. Osterman, Bessel A. van der Kolk. "Awareness during anesthesia and posttraumatic stress disorder" *General Hospital Psychiatry* 20 (1998) 274–281.


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Nonetheless, the possibility is acknowledged in some contexts. That Australian Society of Anaesthetists' web site, as well as reassuring patients that their first words after surgery may be "when will you start?" also attends to the greatest fear of many:

> It is extremely unlikely that you will be awake during a general anesthetic, but it is possible. There have been descriptions of patients who can recall events that occurred during the operation when they were apparently anaesthetized. This recollection is called awareness.

Although awareness is again limited to what can be explicitly recalled, the clinician's role in helping claim the experience is emphasized: "Explaining what probably occurred is the first step in helping these patients to overcome the severe psychological distress and trauma that some have suffered from *no one believing that they were awake* during the procedure."[8] The trauma is not attributed to the awareness at all, but to invalidation of the patient's account of the experience. Such invalidation follows from medicine's fearful inability—or refusal—to engage patients after the operation—and maybe even before it—in exploring the effects and limitations of general anesthesia, and in participating in what Fanny Burney called the *tying up*, afterwards, of that second surgical wound, the traumatized narrative.

## Works Cited

Australian Society of Anaesthetists, *All About Anaesthesia: Information for Patients*. web. 2016. www.allaboutanaesthesia.com.au. Web.

Blacher. Richard. "On Awakening Paralyzed during Surgery: A Syndrome of Traumatic Neurosis." *Journal of the American Medical Association* 234 (1975): 67-68. Print.

Brison, Susan. *Aftermath: Violence and the Remaking of a Self* . Princeton, NJ: Princeton University Press, 2002. Print.

Burney, Frances. *Journals and Letters*. Ed. Peter Sabor and Lars E. Troide. New York: Penguin Classics, 2001. Print.

Caruth, Cathy. *Unclaimed Experience: Trauma, Narrative, and History*. Baltimore: Johns Hopkins University Press, 1996. Print.

Cathy Caruth, ed. "Introduction." *Trauma: Explorations in Memory*. Baltimore: Johns Hopkins University Press, 1995. Print.

Cremeans-Smith, Julie K, Thomas A. Krupko, Kenneth Greene, and Douglas L. Delahanty, "Predicting Symptoms of Post-Traumatic Stress among Patients Undergoing Orthopedic Surgery on the Basis of Routinely Collected Cardiovascular Data." *Journal of Health Psychology* 18.1 (2012): 55-64. Print.

Dale, Jamieson. *Chasing Beauty: My Cosmetic Surgery Takeover*. CreateSpace Independent Publishing, 2009. Print.

[8] See also Vulser et al: there is "evidence that doctors' skepticism with regard to the IA experience is linked with higher levels of anxiety in patients" (95).


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Ghoneim, Mohamed M. and Michael W. O'Hara, "Depression and Postoperative Complications: An Overview" *BioMed Central Surgery* 16.5(2016) doi: 10.1186/s2893-016-0120-y. Web.

Herman, David, et al, eds. *The Routledge Encyclopedia of Narrative Theory*. New York, Routledge, 2005. Print.

Kaysen, Susanna. *Girl, Interrupted*. New York: Vintage, 1994. Print.

Kent, CD, GA Mashour, NA Metzger, et al. "Psychological Impact of Unexpected Explicit Recall of Events Occurring during Surgery Performed under Sedation, Regional Anesthesia, and General Anesthesia: Data from the Anesthesia Awareness Registry." *British Journal of Anesthesia* 110.3 (2013): 381-87. Print.

Kerssens, Chantal, Jan Klein, and Benn Bonked. "Awareness: Monitoring *versus* Remembering What Happened." Anesthesiology 99.3 (2003): 570-575. Print.

Larsen, Jen. *Stranger Here: How Weight-Loss Surgery Transformed my Body and Messed with my Head*. Berkeley: Seal Press, 2013. Print.

Lucas, Geralyn. *Why I Wore Lipstick to my Mastectomy*. New York: St. Martin's Press, 2004. Print.

McNally, Richard J. *Remembering Trauma*. Cambridge, MA: Belknap Press, 2005. Print.

Osterman, Janet E. and Bessel A. van der Koll. "Awareness during Anesthesia and Posttraumatic Stress Disorder." *General Hospital Psychiatry* 20 (1998) 274–281. Print.

Pederson, Joshua. "Speak, Trauma: Toward a Revised Understanding of Literary Trauma Theory." *Narrative* 22.3 (2014): 333-353. Print.

Plath, Sylvia. "Face Lift." *The Collected Poems*. New York: Harper Perennial, 1992: 155-156. Print.

Prince, Gerald. "The Disnarrated." *Style* 22 (1988): 1-8. Print.

Reiner, Jon. *The Man Who Couldn't Eat*. New York: Gallery Books-Simon and Schuster, 2011. Print.

Sanders, Robert D, Guilin To noni, Steven Laurels, et al. "Unresponsiveness [is not equal to] Unconsciousness." *Anesthesiology* 116.4(2012):946-59. Print.

Snow, Stephanie J. *Blessed Days of Anaesthesia: How Anaesthetics Changed the World*. Oxford: Oxford University Press, 2008.

Tougaw, Jason Daniel. *Strange Cases: The Medical Case History and the British Novel*. New York: Routledge, 2006.

Vulser, H, G Airagnes, et al., "Psychiatric Consequences of Intraoperative Awareness: Short Review and Case Series." *General Hospital Psychiatry* 37 (2015): 94-95. Print.

Wall, L. Lewis and Douglas Brown. "Ethical Issues Arising from the Performance of Pelvic Examinations by Medical Students on Anesthetized Patients." *American Journal of Obstetrics and Gynecology* 190.2 (2004):319-23.

Wells, H.G. "Under the Knife." *Selected Short Stories of H. G. Wells*. Ed. Ursula Le Guin. New York: Random House Modern Library, 2004: 51-63. Print.


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